Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Navigator by Tufts Health Plan Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification For Student Coverage" prior to the dependent's 19th birthday. If you are interested in applying for student coverage, complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/ Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, Tufts Health Plan, the administrator of the Navigator Plan, will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or Tufts Health Plan when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling Tufts Health Plan at 1.800. 870.9488.

The Plan can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see our website www.mass.gov/gic

3/2004

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NAVIGATOR BY TUFTS HEALTH PLAN
STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to the Tufts Health Plan. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify the Tufts Health Plan when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Tufts Health Plan, Attn: Commonwealth of MA Enrollment
705 Mount Auburn Street, PO Box 9186
Watertown, MA 02471-9186

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

3/2004